

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-016834

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4147

STATE FILE NUMBER

FILED MAY 1 1962

VS 300
Rev. 4/59

1

2 225

3

4 1

5 2

6

7 0

8 2

9

10

11

12 70-2

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>3 wks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Park Lane Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>30 Plaza Square</u>	
3. NAME OF DECEASED (Type or print) First <u>MATHILDA</u> Middle <u>E.</u> Last <u>GRONEMEIER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20th</u> Year <u>1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Mo.</u>
13a. FATHER'S NAME <u>John Oth</u>		14. NAME OF HUSBAND OR WIFE <u>William Gronemeier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT Address <u>Lillian Lance, 30 Plaza Square</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>420.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Phlebotomy</u>			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. / p.m. Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>March 1959</u> to <u>April 19, 1962</u> and last saw her/him alive on <u>April 19, 1962</u> Death occurred at <u>1:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>12000 Bellefontaine St. St. Louis 38</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>4/23/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>DIEDRICH FUNERAL HOME, 8319 Hallsferry</u>		25. DATE RECD. BY LOCAL REG. <u>APR 23 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

Embalmer

State of

City of

County of

On this day of

19

at

between

and

X

of

State of

Witness my hand and seal

at

this day of

19

at

State of

Embalmer's License No.

Signature of

of

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Invoice

Embalmer's License No. _____